

25 January 2019

Ms Mikaela Meggetto
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Registrar

Re: COR 2017 000935: The death of Sununtha Suttha

I refer to the Finding made by Coroner Jamieson, which included three recommendations. I am authorised by Northern Health to respond to those recommendations.

1. **That Ms Suttha's case be discussed at The Northern Hospital's ED 'morbidity and mortality meeting', highlighting the clinical red flags of aortic dissection, the cognitive biases and system issues involved in the case, as well as the strategies to combat these.**

This recommendation has already been implemented by Northern Health.

2. **That The Northern Hospital utilise a structured cognitive de-biasing strategy such as the NSW Clinical Excellence Commission's 'Take 2, think do' for all discussions between junior staff and senior staff and for transitions in care in the department such as handovers and transfers to the Short Stay Unit.**

This recommendation has been reviewed by relevant, internal quality assurance bodies at Northern Health. Northern Health is investigating how best it may be able to utilise Structured Cognitive De-Biasing strategies.

3. **That Northern Health management ensure adequate senior staffing to allow adequate supervision of junior staff is possible. Staffing levels - both number and seniority - should reflect workload.**

Northern Health has implemented a staffing model for calendar year 2019 in the Emergency Department with a view to maximising the presence of senior medical practitioners for the benefit of both patients and junior medical staff, within the financial constraints of available funding.

Yours sincerely



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Chief Legal Officer

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